Medicaid Definitions

1115 waiver — A waiver which provides a state with the flexibility to develop innovative programs, but also requires cost neutrality and extensive research and documentation for an evaluation of the demonstration. There are three Medicaid programs operating under 1115 waivers in Wisconsin. They are BadgerCare, Family Planning and SeniorCare.

1915 b waiver — A federal Medicaid waiver that permits states to waive specific Medicaid requirements including freedom of choice. The four 1915(b) freedom of choice waivers include: enrollment into managed care, utilization of a "central broker," utilization of cost savings to provide additional services, and limits on the number of providers for services.

1915 c waiver - Home and community-based services waiver — A waiver which permits States to provide expanded community supports to elderly and disabled people who would otherwise require living in an institution or nursing home. People must still meet an institutional Level of Care. Examples of flexible community supports include daily living skills training, supportive home health care, adaptive equipment, respite, and supported employment.

AFDC - Aid to Families with Dependent Children — A former public assistance program under Title IV-A of the Social Security Act of 1935, as amended, and ss. 49.19 to 49.41, Stats. Replaced by TANF. Medicaid eligibility for families with children is still determined using the criteria and standards from the AFDC program.

AFDC-related person — A person who meets AFDC eligibility criteria and qualifies for Medicaid services.

BC - BadgerCare — The Medicaid-related program designed to provide access to health care for low-income families with dependent children. It is Wisconsin's State Children's Health Insurance Program authorized under Title 21 (SCHIP).

BIW - Brain Injury Waiver — A Medicaid 1915c waiver that serves a limited number of people with brain injuries who need significant supports in the community. The person must be receiving or is eligible to receive post-acute rehabilitation services in a nursing home or a hospital with a special unit for brain injury rehabilitation.

Budget neutrality — A requirement in an 1115 demonstration waiver, based on an assertion that diverging from the federal law from which exception is sought will not result in additional costs. Ideally, the change will result in savings.

Card services — Services provided to a Medicaid recipient, as detailed in the Medicaid state plan. To be contrasted with waiver services, which are provided under an exception from federal law.

Categorically needy — Persons who meet both the non-financial and financial eligibility conditions to be eligible for AFDC, SSI or one of the other groups covered under Medicaid.

CB - Community-based — Services provided to a recipient in a non-institutional setting and not in a nursing home or a hospital.

CB-MAC - Community-based Medicaid administrative claiming — A process for claiming federal Medicaid matching dollars for Medicaid administrative activities in the counties (temporarily suspended).

Children's Long Term Support Waivers — Three children's home and community-based services waivers for children with developmental disabilities, physical disabilities and severe emotional disturbance. The waivers include a broad array of community supports including intensive in-home autism treatment services for children with an autism spectrum disorder. Autism services provide up to three years of intensive intervention to develop new and more effective patterns of interaction, learning and communication for children with these diagnoses.

CIP IA - Community Integration Program IA — A federally approved Medicaid 1915c waiver program which provides community services to help low income people with developmental disabilities who are relocated from the State Centers for the Developmentally Disabled.

CIP IB - Community Integration Program IB — A federally approved Medicaid 1915c waiver program which provides community services to help low income people with developmental disabilities who are relocated or diverted from nursing homes and ICF-MRs other than the State Centers for the Developmentally Disabled.

CIP II - Community Integration Program II — A program within the 1915c COP-Waiver, serving the same population, but the GPR funding is in the Medicaid budget based on the closure of a nursing home bed.

CMS - Centers for Medicare and Medicaid Services — The federal agency that administers the Medicare and Medicaid programs.

COB - Coordination of benefits — Process for assuring that Medicaid is the payer of last resort. A provider is required to make a reasonable effort to exhaust all existing health care insurance and Medicare before billing Medicaid, unless the services are not covered by insurance or Medicare.

COP - Community Options Program — Provides GPR funding to county agencies for community-based long term care services to serve low income individuals who meet a nursing home level of care. Funding serves 5 target groups: elders, persons with developmental or physical disabilities, persons with serious mental illness, or alcohol/ drug abuse. Funding is used for non-waiver eligible people, non-waiver allowable services or as match for waiver services.

COP-W - Community Options Program Waiver — A federally approved Medicaid 1915c waiver program which provides services to help low income elders and people with physical disabilities to remain at home if they have long term care needs and would be eligible for Medicaid in a nursing home.

Cost-sharing — A requirement that the recipient of a Medicaid service or a service under a related program contribute to the cost of the service. Cost sharing mechanisms include co-payments and deductibles.

CSDRB – Community services deficit reduction benefit — see WIMCR.

CSLA – Community Supported Living Arrangement — A type of home and community-based services 1915c waiver for people with developmental disabilities. The DHFS did not renew this waiver and instead combined with CIP 1B.

CY - Calendar year — January 1 through December 31.

DCFS - Division of Children and Family Services — The Wisconsin Department of Health and Family Services entity that focuses on issues, policies and programs affecting children and families, and has the responsibility for the regulation and licensing of child care and child welfare programs.

DDES - The Division of Disability and Elder Services — The Wisconsin Department of Health and Family Services entity that has 3 main areas of focus: 1) long term support for the elderly and people with disabilities, including Medicaid home and community-based waivers; 2) mental health and substance abuse services; and 3) regulation and licensing.

DHCF - Division of Health Care Financing — The Wisconsin Department of Health and Family Services entity responsible for administering the Medical Assistance (Medicaid), Chronic Disease Aids, Health Insurance Risk Sharing Plan (HIRSP) and General Relief programs.

DHFS - Department of Health and Family Services — The Wisconsin Department where Medicaid and other health care programs are located.

DHHS - Department of Health and Human Services — The federal department in which Medicaid and other health care programs are located. CMS is an agency within DHHS.

DME - Durable medical equipment means equipment which can withstand repeated use, is primarily used for medical purposes, is generally not useful to a person in the absence of illness or injury and is appropriate for use in the home.

DMS – Disposable medical supplies are disposable, consumable, expendable or non-durable medically necessary supplies which have a very limited life expectancy.

EPSDT - Early and periodic screening, diagnosis and treatment services — Known in Wisconsin as "HealthCheck." It is a preventive health check-up program for anyone under the age of 21 who is currently eligible for Wisconsin Medicaid or BadgerCare. It consists of a comprehensive screening of eligible recipients, which includes the following: review of growth and development; identification of potential physical or developmental problems; preventive health education; and referral assistance to appropriate providers of service.

Family Care — A managed care model of providing long-term care services by combining traditional Medicaid card long term care benefits and waiver services through a managed care organization. It is being piloted in 5 Wisconsin counties. Family Care has both 1915b and 1915c waivers.

FFP - Federal financial participation — The federal portion of money for Medicaid services.

FFS - Fee-for-service — The system of reimbursement for Medicaid services where each service is billed by the Medicaid-certified provider to the Medicaid program and reimbursed accordingly, in contrast with managed care.

FFY - Federal fiscal year — October 1 through September 30.

FMAP - Federal Medical Assistance Percentage — The Federal matching rate for states' Medical Assistance expenditures under their Medicaid programs.

FPL - Federal poverty level or line — The federal poverty guidelines by family size updated annually by the federal government. Eligibility for Medicaid and related programs includes benchmarks calculated as a percentage of the FPL.

FPW - Family Planning Waiver — Coverage for Wisconsin females of child-bearing age for family planning services. Under an 1115 waiver from CMS, Medicaid services were expanded to cover a limited array of services to specific individuals who would not otherwise be eligible for Medicaid coverage.

FQHC - Federally Qualified Health Center — Medical clinic in an under-served area, that receives federal grant funds and receives special reimbursement from both Medicare and Medicaid.

Fiscal agent — The vendor who is contracted by the state Medicaid agency to provide and operate the MMIS and perform other administrative, analytical and clinical services to assist the state in administering the Medicaid program. EDS is currently the Medicaid fiscal agent, and recently was re-awarded the contract.

HCFA - Health Care Financing Administration — The former name of CMS, the federal agency that administers the Medicaid and Medicare programs.

HealthCheck — Wisconsin name for the federally mandated program known as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). It is a preventive health check-up program for anyone under the age of 21 who is currently eligible for Wisconsin Medicaid or BadgerCare. It consists of a comprehensive screening of eligible recipients, which includes the following: review of growth and development; identification of potential physical or developmental problems; preventive health education; and referral assistance to appropriate providers of service.

Healthy Start — A Medicaid eligibility category enabling pregnant women, babies, and children under 19 years of age to enroll in Medicaid.

HIPP - Health Insurance Premium Payment — A program whereby Wisconsin Medicaid pays or reimburses families for their private health insurance premiums if it is cost effective for Medicaid to do so.

ICF - Intermediate Care Facility Services — A level of care that is provided to nursing home residents that does not require the direct supervision of a professional nurse. About 7% of nursing home residents require the ICF level of care.

ICF-MR - Intermediate Care Facilities for the Mentally Retarded — The federal designation for institutions providing care to developmentally disabled residents, such as the state centers. In Wisconsin's Administrative Code they are known as Facilities for the Developmentally Disabled.

IGT - Intergovernmental Transfer — A mechanism whereby a State provides the non-federal share of MA expenditures by transfer of funds from local units of government to the state.

IM - Income maintenance — The group of benefit programs administered by DHFS and the county/tribal agencies. These are Medicaid/BadgerCare, Food Share, Caretaker Supplement and Funeral and Cemetery Aids. IM Administration refers to the statutory and contractual relationships between DHFS and the county and tribal agencies operating these programs.

IMD - Institution for Mental Diseases — A hospital or nursing home that primarily provides care to residents/patients that are mentally ill. Any resident/patient aged 21 to 65 is not eligible for Medicaid per federal statute. The state mental health institutes of Mendota and Winnebago are IMDs.

LTC – Long term care — Includes Medicaid services such as nursing home, personal care, home health, private duty nursing, COP and CIP services.

MA - Medical Assistance, or Medicaid — Medicaid is a program that pays for medical assistance for certain individuals and families with low incomes and resources. Title 19 of the Social Security Act became law in 1965 and is jointly funded by the federal and state governments to assist states in paying for medical services to people who meet certain eligibility criteria. Medicaid is the largest source of funding for medical and health-related services for people with limited income.

MA trust fund — A separate, nonlapsible trust fund where certain revenues are deposited to insure their use for the Medicaid program. Currently, revenues include: (a) a portion of the bed assessment on nursing home beds; and (b) revenues transferred from counties to the state to support Medicaid payments to nursing homes. Created by state statute in 2001.

MAC – Medicaid administrative claiming — Activities, not medical services, that are directly related to the administration of the Medicaid program and are eligible for federal matching dollars.

MAPP - Medicaid (MA) Purchase Plan — A plan in which working adults with disabilities whose family net income is less than 250% of the poverty line are eligible to purchase Medicaid coverage on a sliding-fee scale.

MC - Managed care — A method of service delivery that involves payment to a health care organization on a fixed per person basis to provide health care services with a focus on improved access and quality.

Medically needy — Persons who meet the non-financial eligibility conditions for one of the categories of Medicaid, but whose income exceeds the financial eligibility limits for those programs. Typically, these persons become eligible for Medicaid only after incurring enough medical expenses to offset their excess income.

MMIS - Medicaid Management Information System — The federally required system to process claims and perform other required functions necessary to administer the Medicaid Program.

OTC - Over the counter — Drugs available without a prescription.

PA - Prior authorization — Authorization required for certain Medicaid services before the services are provided to the recipient.

Presumptive eligibility — A procedure by which a qualifying provider determines that a woman meets certain basic Medicaid eligibility requirements and certifies her Medicaid eligibility for a temporary period of 2 to 3 months. Women can be found presumptively eligible for Well Woman Medicaid, the Family Planning Waiver and Healthy Start (Medicaid for pregnant women).

QMB - Qualified Medicare Beneficiary — Special category of Medicaid recipients who receive Medicare insurance premium payments. Medicaid also pays for Medicare coinsurance and deductibles.

RHC - Rural Health Clinic — A medical clinic in an under-served rural area that receives special Medicaid and Medicare reimbursement.

SBS - School-based services — A Medicaid benefit that reimburses school districts for medically related special education and associated services for children who are Medicaid recipients.

SC - SeniorCare — A Wisconsin program of prescription drug assistance for eligible elderly persons established under Wisconsin statute and funded in part through an 1115 waiver.

SCHIP - State Children's Health Insurance Program — The federal program to provide health insurance coverage for lower income children who are not eligible for Medicaid. It was established through the enactment of Title 21 of the Social Security Act. Wisconsin's SCHIP program is BadgerCare.

SFY - State fiscal year — In Wisconsin, July 1 through June 30.

SLMB - Specified Low-income Medicare Beneficiaries — Persons who meet the criteria to be considered elderly, blind or disabled by the Social Security Administration, and have income between 100% and 120% of the federal poverty level. Those persons who qualify as an SLMB, have their Medicare Part B premiums paid for by the Medicaid program.

SNF - Skilled nursing facility services — A level of nursing home care that requires the direct supervision of a professional nurse. About 93% of nursing home residents require skilled care.

SSDI - Social Security Disability Insurance — Persons no longer able to work due to a disability, will receive Social Security benefits through this program based on their past earnings and Social Security contributions. Persons receiving these benefits and whose total income and assets are below the SSI-Related standards may qualify for Medicaid.

SSI - Supplemental Security Income — The assistance program under Title XVI of the Social Security Act of 1935, as amended, and s. 49.177, Stats. Persons receiving SSI automatically qualify for Medicaid. Persons who do not receive SSI but meet the SSI eligibility criteria also qualify for Medicaid.

TB — Tuberculosis - An optional Medicaid coverage group, for persons infected with tuberculosis and whose income and resources do not exceed SSI standards. Benefits are limited to those services related to the treatment of tuberculosis.

Therapeutic class — A group of specific drug entities classified according to use - i.e., anti-convulsants.

Title 18 — The portion of the Social Security Act pertaining to the Medicare program - "Health Insurance for the Aged and Disabled."

Title 19 — The portion of the Social Security Act pertaining to the Medicaid program - "Grants to States for Medical Assistance Programs."

Title 21 — The portion of the Social Security Act pertaining to the "State Children's Health Insurance Program."

Title IV-E — The portion of the Social Security Act which provides eligibility requirements for foster care children. Federal foster care administrative funds are available for services to children in out-of-home placement (foster care) if they meet the Title IV-E requirements.

TPL - Third party liability — See coordination of benefits, or COB.

WIMCR - Wisconsin Medicaid cost reporting — A cost-based payment system for counties that are certified as Medicaid providers of community services that resulted in additional federal funding for Medicaid. (2003 WI Act 318)

WW - Well Woman Program — A state/federal program intended to help uninsured low-income women from ages 35 to 65 obtain screenings to detect breast or cervical cancer. The Division of Public Health administers the WW program. Any women diagnosed with cervical or breast cancer through the State's WW program qualify for WW Medicaid until they are free of the cancer.